

# At a glance

## CARE International's Community-Based Distribution Program in Eastern Ethiopia Increases Contraceptive Use

By Marcie Rubardt

### SUMMARY: A FAMILY PLANNING SUCCESS STORY IN RURAL ETHIOPIA

*"Previously we believed [pregnancy] was an act of God—but we have a mind to think and we can also use it."*

Against the odds, a difficult message (family planning) for a traditionally resistant audience (rural communities), the CARE's Population and AIDS Prevention Project increased modern contraceptive use in the Oromiya region of Ethiopia six-fold—from 4 percent to 24 percent—while the number of adults who knew at least two modern contraceptive methods increased from 48 percent to 73 percent. How did it happen? The project owes its success to a number of factors:

- Emphasizing the economic benefits helped convert initially reluctant and suspicious community leaders into family planning advocates as they began to understand the economic consequences of large families on the health and general well-being of individuals and the community.
- Distinguishing between natural and "official" leaders, between those who genuinely influence public opinion and those who merely have political power, and enlisting the support of the former was instrumental in establishing the "culture" of family planning.
- Using men, the primary decision-makers in reproductive health, as the community-based reproductive health agents was an effective strategy for minimizing the social costs of contraception to women.
- Raising awareness of the benefits of family planning through social mobilization was key to increasing contraceptive demand.
- Collaborating with the Ministry of Health (MOH) made it possible to provide good training to the Community-based Reproductive Health Agents (CBRHAs) and also provided a platform for ongoing support (both material and supervisory) and sustainability.
- Using assessment tools to learn about the community gave program staff solid information on which to base their interventions.
- The ready availability of the necessary pills and other contraceptive methods helped to establish and sustain the habit of family planning and to cut back on the number of dropouts.

*"Until someone tastes honey, they don't know it is sweet. But once they taste, they realize it is very good. That is like us with family planning."*

### Inside:

The Family Planning Component of the POP/AIDS Project .....	2
Overall Project Strategy .....	3
The IEC Strategy .....	4
Role of the CBRHAs .....	6
Role of Health Services .....	7
Project Results .....	9
Critical Success Factors .....	11

**Project Coordinator:** Dr. Solomon Tesfaye  
**Project Implementation:** CARE Ethiopia  
**Project Funding:** Netherlands Government

**Technical Editors:** Nazo Kureshy, Marge Koblinsky  
**Editor:** Charlotte Storti  
**Design:** Cecilia Snyder  
**Dissemination Coordinator:** Martha Langmuir

## Introduction

As part of its agenda to document promising efforts in community-based reproductive health, NGO Networks for Health studied the family planning component of CARE Ethiopia's Population and AIDS Prevention Project (POP/AIDS). This exercise followed up on evaluation data which had indicated that project interventions led to significant increases in the use of family planning, in the attitude of couples towards their reproductive goals, and in their communication about family planning. The purpose of the exercise, conducted by NGO Networks consultant Marcie Rubardt, was to document how the project was implemented and identify the factors that contributed to its success, and in particular how CARE increased the contraceptive prevalence rate in project areas from 4% to 24% in four years.

This exercise examined results in two of the three zones served by the project, one with the highest and one with the lowest contraceptive prevalence rate as indicated in the final project survey. For comparison purposes, a brief visit was also made to a village where the project had not operated.

The consultant worked closely with a nurse midwife to conduct focus groups and key informant interviews in a total of five Peasant Associations in the two zones. Those interviewed included natural leaders, women and men (including users and non-users of modern contraceptive methods and drop-outs), CBRHAs, CARE extension agents, health clinic staff, and CARE staff supervisors.

Interviewees were asked about the strategy for introducing the family planning program in their villages, attitudes towards family planning, and the factors responsible for increasing acceptance and maintaining use of family planning.

## The Family Planning Component of the POP/AIDS Project

Ethiopia has a total population of about 64 million people, the majority of whom live in rural areas which tend to be highly traditional and clinically underserved. POP/AIDS, a five-year effort funded by the Dutch government, was implemented in 1996 in three zones of the rural Oromiya region with below average health statistics, including baseline family planning awareness among women and men of less than 50 percent and a contraceptive prevalence rate of less than 5 percent (Source: Family Planning & HIV/AIDS Prevention Project Final Evaluation Report; August 2001).

## Project Zones



Total population in the three project zones: 260,000

## FACTS AT A GLANCE: ETHIOPIA AND OROMIYA

### Population

Ethiopia	63.5 million
Oromiya	20.0 million

### Literacy in Ethiopia

Men	39.6%
Women	18.5%

**Total Fertility Rate** 5.9

### Contraceptive Prevalence Rate by Currently Married Women (Age 15 - 49):

#### Ethiopia

Any Method	8.1%
Any Modern Method	6.3%

#### Oromiya

Any Method	6.6%
Any Traditional	2.3%
Any Modern Method	4.3%
Oral Pills	1.9%
Injectables	1.6%
Condom	0.4%

Source: Demographic & Health Survey, Ethiopia, 2000

The overall goal of the project was to improve the health status of women and children in the selected communities, with a special emphasis on reproductive health. The objectives of the family planning component of POP/AIDS were to:

- 1) increase knowledge and enhance attitudes and practices regarding the use of effective family planning methods, and
- 2) increase sustainable access to affordable contraceptive methods by 2001.

## Overall Project Strategy

The family planning component of POP/AIDS used a four-step approach known as the Phase-In/Phase-Out Strategy. This strategy involves a CARE extension agent living and working intensively in a targeted Peasant Association (4-9 villages) for six months to build local interest in and support for family planning.

**Phase One: Social Mobilization** (three months). During the first phase, CARE extension agents (see box, p.4) move into a targeted Peasant Association (PA), introduce themselves and their purpose, and begin working with the community in a participatory way to increase awareness of and overcome barriers to family planning use. The agents use tools such as social mapping, mapping of all the eligible couples (ELCOs)<sup>1</sup> of reproductive age for family planning, and identifying the natural, as opposed to the formal, leaders and orienting them to the purpose of the project. Agents also begin distributing pills and condoms, and make referrals to the health clinic for additional reproductive health services. The success of this phase, the most difficult of all, depends almost solely on the level of activity and degree of commitment of the extension agents. While this approach echoes in some respects the ongoing efforts of the MOH and CBRHA volunteers, the technique of using trained community mobilizers living in a PA for six months with the sole task of initiating family planning added a significant new dimension to this intervention.

**Phase Two: Identifying and Training CBRHAs** (three months). Once natural leaders have been persuaded of the value of family planning and initial awareness regarding family

<sup>1</sup>As part of the initiation phase, the extension agent maps every eligible couple of reproductive age in the village and then establish registers for tracking these couples and their family planning status. This process clearly identifies households to be targeted for family planning education and services. The register as well as the ELCO map are updated by the CBRHA as a couple's fertility status changes.

planning has been achieved, the extension agent works with the community to identify and select CBRHAs. These CBRHAs work closely with the extension agents during an initial orientation period and then go for their formal training which uses a national CBRHA training curriculum. When they return from their training, the CBRHAs begin to assume the duties of the extension agent, under close supervision.

**Phase Three: Handover** (three months). Once the community is convinced of the benefits of family planning and the CBRHA is well trained, the extension agent finalizes the handover of his/her activities to the CBRHA, being sure to closely involve the natural leaders in the process. After the handover, the extension agent moves on to the next targeted village but returns to the Peasant Association for seven days each month for a period of three months to provide follow-up support and supervision as necessary.

**Phase Four: Phase Out.** Apart from their attendance at monthly meetings at the health clinic, the involvement of the extension agent

continues to decrease as the health clinic staff and natural leaders take increasing responsibility for the support of the CBRHA activities on-site.

### *The Information, Education, and Communication (IEC) Strategy*

This project focused almost exclusively on family planning during the first six months of its activities, which consisted of an intensive dose of family planning information undiluted by other health messages. The project later phased-in messages focusing on HIV/AIDS.

The IEC strategy minimized social barriers to family planning by emphasizing the following factors:

**Economic Benefits of Family Planning.** While the health benefits to the mother and child were included in all IEC messages, the primary message in the more successful villages focused on the economic benefits of family planning. Many community members were initially suspicious of extension agents, but they

## **ROLES AND RESPONSIBILITIES OF THE KEY PLAYERS**

**CARE extension agents** are the catalyst for initiating family planning activities and acceptance in the targeted PAs. Working closely with natural leaders during the first two phases, extension agents help establish the “culture” of family planning in the village. Agents are also responsible for providing supervision and follow-up for PAs in later phases, and for working with the health clinics to encourage their ownership of the activities.

**Natural leaders**, identified through a social mobilization process by the extension agents, are the “backbone” of activities in the community. They gather people together for education and support, facilitate the work of the CBRHA in the village, and are a key influence on people’s opinion and acceptance of family planning. It is through the involvement of natural leaders that the “culture” of family planning gains acceptance in the village. It is important to emphasize that natural leaders may not necessarily be the official or political leaders in the community. While the tacit approval of these formal or political leaders is important, they normally play a limited role in the ongoing change in family planning use.

**CBRHAs** are responsible for maintaining family planning clients by providing pills and condoms, by counseling clients on side effects, by making referrals to the health clinic, by reminding pill and Depo-Provera users who may forget to maintain their use, by recruiting new clients where feasible, and by providing additional health education. They also do a monthly report and attend a monthly meeting at the health clinic to review the program and pick up supplies.

**Health clinic staff** take increasing responsibility for overseeing the activities of the CBRHAs and providing contraceptive supplies. They manage monthly CBRHA meetings with the support of the CARE staff, review CBRHA reports, receive and manage referrals, and provide contraceptive supplies. They may also occasionally do joint supervision of CBRHA activities with CARE staff. In the long run the monthly meetings will become the primary mechanism for health clinic staff to support the activities of the CBRHAs. It is likely that outreach supervision will probably not continue unless it can be done in conjunction with other (funded) outreach activities, such as immunizations.

became more receptive when they began to understand the agents' message about the link between poverty and family planning.

### **Working with Natural**

**Leaders.** Identifying, convincing, orienting, and involving natural leaders in the behavior change process at the community level was key to the Phase-In/Phase-Out strategy. Natural leaders are the opinion leaders, not the official or political leaders, in the community, and once they are convinced of the need for family planning, they serve as change agents to facilitate wider acceptance in the community. In the active communities, the leaders were quite influential, fully committed to the program and actively participating in the activities. In the less active communities, not much effort was made to identify and orient natural leaders, and the project depended more on the formal leadership system.

CARE extension agent teaches a new mother from West Hararghe how to use contraceptives.  
*Photographer: Solomon Gudina/CARE, 1998*

**Male Involvement.** It was recognized at the outset of the project that in this culture men made the key decisions concerning reproductive health. Accordingly, the IEC strategy had men as its primary target audience, and the project included a number of elements designed to appeal to this audience, such as emphasizing the economic benefits of family planning, using natural leaders as change agents and message transmitters, and selecting male CBRHAs and extension agents.

#### **SELECTED ACHIEVEMENTS OF THE CARE/POP/ AIDS PROJECT (1996-2001)**

- The percentage of women aged 15-49 currently using a modern contraceptive method increased from 4 percent to approximately 24 percent. In the more active areas, some of the most remote and traditional in Ethiopia, contraceptive use reached 32 percent.
- The percentage of adults who could cite at least two methods of modern contraception increased from 48 percent to 73 percent.
- In the previous year, currently married women who discussed the number of children they would like to have with their spouses increased from 7 percent to 34 percent.
- A significant proportion of current users (39 percent) are served by CBRHAs, indicating the key role they play in counseling and distributing contraceptives.
- CARE's extension agents were able to successfully transfer outreach responsibilities to the CBRHA volunteers and support responsibilities to the health clinics.
- Access to condoms and pills was reliable in 111 Peasant Association areas (approximate population: 260,000) with services from 344 CBRHAs.

Source: *Final Evaluation Report: CARE Ethiopia Family Planning and HIV/AIDS Prevention Project, August, 2001.*



## The Role of the Community-Based Reproductive Health Agents

The CBRHA is the lynchpin of the Phase-In/Phase-Out approach. While the extension agents and, later, the health clinic staff play key development and support roles, the sustainability and ultimate success of the effort rest with the CBRHA.

**Selection.** CBRHAs were selected in a participatory way after extension agents had spent three months working in a community. The selection criteria, which were generally consistent across project areas and with the national program, included being trustworthy, literate, willing to volunteer, and able to learn and do the extension agent's job. One CBRHA was selected per village, which resulted in approximately 4-9 CBRHAs in a Peasant Association, depending on the size of the association. A typical CBRHA might manage anywhere from 70 to 140 eligible couples. The literacy criterion meant that almost 90 percent of the CBRHA cadre was male.

### NUMBER OF CBRHA TRAINED (1996-2001) IN THREE PROJECT ZONES

Zone	CBRHAs Trained
West Hararghe	107
East Hararghe	133
East Shoa	104
<b>Total</b>	<b>344</b>

**Duties.** There are two main tasks involved in assuring family planning use at the community level: generating awareness and acceptance and then maintaining use. The first tends to be more difficult as it often challenges traditional beliefs and therefore requires considerable commitment to overcome local resistance. In the POP/AIDS model, the paid CARE extension agent assumed most of this burden.



Women leaders in Mekanisa village of West Hararghe have been targeted by the CBRHA and extension agents to initiate family planning use for themselves as well as to educate their friends on the benefits.  
*Photographer: Marcie Rubardt, 2001*

Once a village becomes convinced of the benefits of family planning, however, the time and effort required to maintain utilization rates are minimal. It is relatively easy, for example, for a CBRHA to maintain the following activities:

- recruitment of new and returning users (involving education and home visits for newly married and post-partum couples)
- counseling on side effects
- referrals and follow-up of referrals
- tracking of Depo-Provera and pill users who may have forgotten
- providing pills
- attendance at monthly meetings to report on the number of pills distributed

**Motivation.** When CBRHAs were first recruited, it was with the understanding that they would be working as volunteers. Halfway through the project, however, a payment of 32 Birr/month (less than \$4) was introduced, which the CBRHAs received when they attended the monthly meeting at the health center.

The interviews indicated that the payments notwithstanding, CBRHAs feel responsible to their communities because they have been specially selected and trained to perform this important service, and they appreciate the recognition and ability to serve. By and large they are not doing it

for the money; indeed, the non-monetary incentives—such as recognition, honor, status, increased credibility and knowledge, and sense of service—were all cited as important factors. In fact, CBRHAs indicated they were interested in opportunities to further enhance their knowledge and broaden their roles in the community.

**Training.** The training of CBRHAs is both informal and formal. Since the formal training uses MOH trainers and the national curriculum, it is the informal component that is unique to this project. After they are selected, CBRHAs work alongside their CARE extension agent, both before and after they receive their formal training. Their pre-training experience gives them the background to understand and apply the formal training content in the community setting. After the training, the new CBRHAs work under the supervision of their extension agent for two to three months, carrying out group education, home visits, and counseling.

**Management and Supervision.** Intensive supervision, including strategies for strengthening weak CBRHAs, is an integral part of the Phase-In/Phase-Out strategy. The seven days per month of supervision during the handover phase allow the extension agent the opportunity to provide

additional support and follow-up for CBRHAs who have recently begun working on their own. For those CBRHAs who may be having a difficult time, extension agents use a number of strategies, including:

- partnering strong CBRHAs with weak ones,
- organizing the CBRHAs among themselves to solve problems,
- developing a sense of teamwork among the group of CBRHAs in a given PA, and
- providing assistance with work plan development.

Establishing a direct link between the health clinic staff and the CBRHA is also important—both for supply systems and for long-term support. While the initial intent was to encourage MOH staff from the clinics to take over supervision in the community, this will probably not happen on a regular basis. It is more realistic to try to encourage clinic staff to supervise CBRHAs when the staff are in the village for other activities and to emphasize the importance of the monthly supervisory meetings at health facilities. To the extent that either side depends on the CARE extension agent to maintain supplies and support, long-term sustainability is undermined. The two successful PAs visited by the consulting team had been phased out a year earlier. Although the CBRHAs in these communities had not been supervised in the field by either a health clinic person or the CARE extension agent for more than seven months, the monthly supervisory meetings were functioning effectively. In some PAs, natural leaders also stepped in to help supervise the CBRHAs.

### *The Role of the Health Services*

While the Phase-In/Phase-Out strategy serves as a catalyst to initiate the family planning activities, the role of the Ministry of Health in supporting the ongoing activities at the community level is central to program success, especially in the areas of providing services for clinical methods and referrals and in assuring a continued supply of contraceptives. Certain key activities of the health services are described as follows.



Male CBRHAs in Mideydu village, supported by their female CARE extension agent.  
Photographer: Marcie Rubardt, 2001



CBRHAs in East Hararghe discuss progress and issues with CARE health supervisors and government health staff.

Photographer: Abdulkadir Mohammed/CARE, 1999

**Monthly Meetings.** Held in collaboration with the CARE supervisory staff, these meetings serve as a forum to discuss issues, to review the CBRHAs monthly reports, to follow up on referrals and track Depo-Provera users, to serve as a mechanism for resupply, and to provide continued supervision. In those areas where health centers were active and involved, these meetings were conducted regularly and were appreciated by the participants. In areas where relations with the health services were less well developed, these meetings took place sporadically or not at all.

**Referral System.** The project instituted a two-part referral system wherein the CBRHA refers clients to the health clinic, and clients later come back to the CBRHA with a report of the consultation. This system allows for follow-up on referrals, as well as an easy way for the health service provider to identify CBRHA clients. Both clients and CBRHAs appreciate the preferential treatment such a referral system offers.

**Supplies.** The project made a significant effort to ensure a consistent supply of pills as well as Depo-Provera at the clinic level. While these supplies are adequate at the national level, problems involving transport, requesting systems, and stock-keeping often create gaps in supplies

at the *woreda* or clinic levels. In addition, there is a significant demand for long-term methods, such as Norplant or IUDs, which has not yet been met and which may pose supply problems at the national level. CARE has occasionally helped out with supply problems by providing transport and offering advice.

**Zone-level Support.** While it is the job of the community to recruit and support the CBRHA volunteers, it is the job of those at the zone level to assist with training and supplies. Ideally, there is good coordination and mutual appreciation between these levels, but the CARE supervisor should work closely with the zone MCH Coordinator to facilitate the necessary linkages.

Ministry of Health policy supports expanding the role of the CBRHAs into other reproductive health areas, such as HIV and other STDs, maternal child health, and traditional practices. Currently, most CBRHAs assist with mobilization for immunization and polio campaigns, as well as in the distribution of Vitamin A. CBRHAs expressed an interest in doing community education for these activities, which suggests that in their minds disseminating these additional messages did not mean additional work, probably because they were already so well integrated into their communities. Several individuals expressed the view that the ability of these volunteers to address a wider range of the health needs in the community enhances the CBRHA's credibility. At the same time, if these additional messages help improve the health of children, this may offset suspicions that the real purpose of family planning is the so-called "limiting the race" agenda. Along with broadening their role in health, there is also the potential for strengthening the linkages between the CBRHAs and other community-level agents working in such areas as



development or agricultural extension. By strengthening these ties, it is possible that the different agents can reinforce each others' activities and also provide mutual support for their role in development in the community.

## Project Results

As reported earlier, the family planning component of the POP/AIDS program was successful in increasing both awareness and use of family planning methods in rural Ethiopia. Awareness (knowledge of at least two types of modern contraceptive methods) increased by 52 percent, and use increased six-fold. In contrast, awareness of and demand for family planning methods remain extremely low in non-project areas. Men indicated that they had heard something about family planning on the radio but not enough to be interested, while women were much less informed.

*"At first we thought this woman (the extension agent) was wanting to make us limit our race and we were suspicious. But then we realized that what she told us was really true in our own house."*

## Changes in Awareness and Attitudes

*Observations from More Active Villages.* In the most active villages, the "culture" of family planning was successfully integrated into everyday village life. Leaders, men, and family planning users were almost passionate about their appreciation for family planning, noting that previously this was a topic they could not talk about, due to lack of awareness and shame, but that they now discussed with their spouses. CBRHAs and users of family planning methods see themselves as role models for promoting use of family planning in their communities.

The norm regarding ideal family size in active villages has decreased to approximately 4-5 children, and families are now seeking long-term methods to control fertility after attaining their desired family size. Community members acknowledged family planning as a possible

means to partially alleviate economic constraints (e.g., cost of food, school, clothes, hygiene, and general care). Villagers were aware of several methods (their advantages, disadvantages, and side effects), and few refused modern contraceptive methods unless they had health problems.

Community members reinforced the belief that male involvement in family planning was essential and that the men need to be convinced first. Couples in these villages were oriented towards discussing and following through on reproductive goals, and they decided how many children they

wanted and the spacing by talking about it together. Many women reported that their husband was the first one to learn about modern contraceptives and convinced them to try a method. Some women were nervous about the side effects but were encouraged by their husbands to use

modern contraceptives. A few natural leaders also mentioned that some couples were choosing to delay their first pregnancy, even though that is generally frowned upon in rural Ethiopia.

*Observations from Less Active Villages.* In the less active villages, in contrast, fewer individuals were aware of the benefits of family planning, and people were more likely to express opinions about why they do not use family planning. For various reasons, people in these villages continue to experience significant barriers to family planning, including the traditional belief that the number of children depends on God's will, the continued pressure of their parents, and the lack of a defined role for the natural leaders in the implementation of the IEC strategy. In most of the active villages, the intense involvement of the natural leaders in mobilizing community interest offset these barriers.

The general acceptance of family planning in the less active villages has not translated into the creation of an environment that enables behavior change. Some women still indicated significant concern about the harmful effects of family planning, in spite of having been well informed and having husbands who were encouraging them to use it. In particular, two common misperceptions persisted: 1) that women naturally space their children (even though they menstruate) and therefore do not need family planning, and 2) that women under medical treatment (e.g., for malaria) cannot continue with family planning.

More women in these villages also complained of side effects despite the attempts by the CARE extension agent and CBRHA to assist in managing them. Women indicated their parents were pressuring them to have a lot of children, and some women still report using modern contraceptives without the participation of their husbands. It was observed that the leaders tended not to be carefully chosen in the less active villages and their roles poorly defined, resulting, in many cases, in leaders who were not themselves using family planning.

## Changes in Access

Although community members acknowledged that awareness was the primary factor that had changed, project staff also felt that increased access to contraceptive methods had made a difference. Prior to the project, pills were available at the most peripheral health stations, but Depo-Provera was not. In addition, supplies were sporadic, people had to travel long distances to a health station, and demand was low.

By making pills available at the community level, the project provided an easy way for women to try family planning with a minimum of effort or commitment. The CARE extension agent or CBRHA were able to simultaneously educate couples on the benefits of family planning and offer the pills. All clients consulted indicated they had begun by using the pill, which they obtained from the CARE extension agent or CBRHA.

With the support of the Ministry of Health, the project helped make Depo-Provera available at the more peripheral health clinics. Once women became convinced of the benefits of family planning, they began to consider these other methods and were willing to travel further to get them. In one community the trip to the clinic for Depo-Provera was two hours' walk uphill, but none of the women complained about the distance because they were so convinced of the

benefits. Most women stated that their preference for Depo-Provera was not due to secrecy but rather because they found the daily pill-taking regimen hard to follow.

## Can These Results Be Sustained?

There were several factors which suggested that active communities had reached a point where their use of contraceptive methods might be sustainable, assuming the continued



In West Hararghe, women learn about pregnancy and childbirth from two CARE extension agents.

Photographer: Abdulkadir Mohammed/CARE, 1997

availability of supplies. “We don’t need CARE, and we don’t even need our CBRHA,” one leader observed, “because when we want family planning, we can just go to the clinic and get what we need.”

Among the factors:

- People stated they would be willing to pay something for their supplies, particularly for Norplant since it is an infrequent expense.
- Many couples acknowledged that they would like to stop childbearing altogether, and they would therefore be an important group to target with an effective long-term method.
- People are walking up to 2-3 hours to get their Depo-Provera injection without complaining. Others are seeking pills from their CBRHA when they are not satisfied with the services at the health center.
- Women indicated they appreciate the work of the CBRHA and would be willing to help with his/her work. This had already occurred in one village when the CBRHA was called away to war.

Maintaining supplies is another essential part of sustaining family planning behavior and a priority for the MOH. While there are adequate supplies at the national level, the logistics involved in maintaining availability at the clinic level have in some cases proven insurmountable. CARE has offered its assistance, especially in the areas of finding transport and identifying stock-outs in a more timely manner, but a systems approach to these recurring problems is needed to assure an uninterrupted supply of products to the *woreda* and clinic levels.

The Government is moving towards the social marketing of condoms, and possibly even pills, since there are some indications which suggest that this might be a more reliable solution to the supply problem. If this happens, the convinced family planning users in the project areas will

Community-based workers advocate for the use of family planning in the Oromiya region.

*Photographer: CARE Ethiopia, 1998*

likely overcome the cost barrier and take advantage of the long-term supply of family planning methods. This may take some getting used to, however, since users have become quite accustomed to free supplies.

### Critical Success Factors

By reviewing the interventions in both active and less active villages, the consultant was able to identify factors that likely contributed to the success of the project. These critical success factors, drawn from the perceptions of key informants, are highlighted below.

**1. An emphasis on the economic benefits of family planning.** Initially reluctant and suspicious, many leaders became family planning advocates when they began to understand the economic consequences of large families on the health and general well-being of individuals and on the community as a whole. The economic message also resonated with community members facing acute land shortages and inadequate food supplies due to the rising population. It is quite telling in this context to note that in some of the less active villages the health messages were emphasized more than the economic ones.

**2. The use of natural leaders.** The effective identification, “conversion,” and mobilization of natural leaders contributed significantly to project success in the active villages. In those villages where project staff did not distinguish carefully between natural and political leaders, between leaders who have influence on public opinion versus those who merely have political power, the culture of family planning did not become firmly established.

**3. The use of literate, mainly male community-based reproductive health assistants.** Literate CBRHAs were better able to master the training curriculum and understand/handle the interpersonal dynamics in the community. As the primary decision-makers in the reproductive health arena, men were considered the better choice for influencing behavior change vis-à-vis family planning.

**4. Social mobilization to increase awareness and acceptability of family planning.** The increased use of contraceptive methods in the target areas was based on a strong foundation of education concerning the benefits of family planning. Once natural leaders and community members had come to value family planning through an intensive social mobilization effort, demand increased considerably. The combination of increased demand and easy access to pills (i.e., in the village itself) was a powerful formula, not only for increased use but also in support of sustainability.

**5. Use of assessment tools to target family planning demand creation and services.** The social mobilization phase of the project succeeded in part because it was based on solid information about local practices and eligible couples, information that was derived from social maps, ELCO maps to identify eligible couples as well as available formal and traditional services and care-seeking practices, and Venn diagrams to identify natural leaders/influential decision-makers and social networks in the community.

**6. Collaboration with the MOH in the training and support of CBRHAs.** The MOH and local health facilities were instrumental in providing the formal training and long-term supervision of the CBRHAs, played a central role in the supply and distribution of contraceptives, and served as a center for referrals.

**7. A reliable supply of contraceptives.** The ready availability of the necessary pills and other contraceptive methods is essential to establish and sustain the habit of family planning and cut back on the number of dropouts.

*NGO Networks for Health would like to thank the following individuals for their support and contributions to this learning agenda inquiry: Colleen Conroy, Theresa Shaver, Ellen Pierce, Solomon Tsefaye, and Patricia Caffrey.*

*A special thanks to Marcie Rubardt, Belaynesh Asfaw, Habtamu Tekelab, the CARE Ethiopia field staff and all the community members for the information which made this collective learning exercise possible.*

NGO Networks for Health (*Networks*) is an innovative five year global health partnership created to meet the burgeoning demand for quality family planning, reproductive health, child survival, and HIV/AIDS information and services around the world. Funded by the United States Agency for International Development (USAID), the project began operations in June 1998. For more information, contact:

NGO Networks for Health  
2000 M Street, NW, 5th Floor  
Washington, DC 20036 USA  
Tel: 202-955-0070  
Fax: 202-955-1105  
Email: [info@ngonetworks.org](mailto:info@ngonetworks.org)  
[www.ngonetworks.org](http://www.ngonetworks.org)

